STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395398	A. BLDG: 00 B. WING:	05/18/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
SOMERSET HEALTHCARE & REHABILITATION CENTER STATE LICENSE NUMBER: **970202**	**228 SIEMON DRIVE** **SOMERSET, PA 15501**

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F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification survey, State Licensure survey, Civil Rights Compliance survey, and a complaint survey completed on May 18, 2023, it was determined that Somerset Healthcare and Rehabilitation Center was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0625 SS=D		F 0625		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0625 SS=D	Continued from page 1 483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:	F 0625	Business Office Manager and Social Worker were educated by the Executive Director on the bedhold letter and bedhold process. Resident 59 and their representative/next of kin was then notified about the facility's bedhold policy by the Social Worker. Licensed staff were educated by the Director of Nursing on 6/8/2023 on the bedhold policy and about the bedhold policy binder to be placed at the nurses' station. The Bedhold Policy binder was placed at the nurses' station with bedhold letters to send at the time of transfer to the hospital. The Social Worker reviews the binder to ensure a resident who just left had a bedhold notification sent. There will be a review of the residents transferred with Medicaid to ensure that they received bedhold notification 5 times a week for 4 weeks then monthly for 2 months. The results of this review will be	Completion Date: **06/09/2023** Status: **APPROVED** Date: **06/08/2023**

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F 0625 SS=D	Continued from page 2	F 0625	reported by Social Services at our monthly Quality Assurance Performance Improvement Meetings.	

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F 0625 SS=D	Continued from page 3 Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that the resident and/or responsible party was notified about the facility's bed-hold policy upon transfer to the hospital for one of 38 residents reviewed (Resident 59). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 59, dated May 3, 2023, revealed that the resident was cognitively impaired, required extensive assistance with daily care needs, and had diagnoses that included diabetes mellitus and chronic kidney disease. Nurse's notes for Resident 59 dated March 22, 2023, at 7:25 p.m. revealed that the resident was admitted to the hospital for a change in condition. There was no documented evidence that the	F 0625		

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F 0625 SS=D	Continued from page 4 resident and/or the responsible party was notified about the facility's bed-hold policy at the time of the above transfer to the hospital for Resident 59. Interview with the Nursing Home Administrator on May 17, 2023 at 9:26 a.m. confirmed that there was no documented evidence that a bed hold notice was issued to Resident 59 or his responsible party and that it should have been. 28 Pa. Code 201.29(d) Resident rights. 28 Pa. Code 211.5(f) Clinical records.	F 0625		
F 0641 SS=D		F 0641		

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F 0641 SS=D	Continued from page 5 483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 0641	Resident #18's MDS (aka Minimum Data Set) assessment was modified at the time of survey to show oxygen use. Resident #8's MDS assessment was modified to code influenza vaccine as none of the above instead of refused. Resident #80's MDS assessment was modified to correct insulin and diuretics. Resident # 25's MDS assessment was modified to correct diuretics/ anticoagulants. Resident #17's MDS assessment was modified to correct bowel incontinence. An initial audit was conducted on all residents last MDS assessments to ensure the following were coded correctly: 1. Oxygen-use while or while not a resident. 2. Influenza Vaccine-consent, decline or refuse 3. Medications-insulin/anticoagulants/ diuretics days recorded use. Registered Nurse Assessment	Completion Date: **06/09/2023** Status: **APPROVED** Date: **06/08/2023**

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F 0641 SS=D	Continued from page 6	F 0641	Coordinators (RNACS) were educated by the Vice President of Clinical Services on the proper coding of the MDS. RNACs will also check each other's coding for accuracy prior to MDS submission. MDS coding will be checked for accuracy and proper coding of oxygen, influenza medications, and bowel continence weekly for 4 weeks then monthly for 2 months by the RNACs. This will then be reported by the RNAC at the monthly Quality Assurance Performance Improvement Meeting.	

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F 0641 SS=D	Continued from page 7 Based on a review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to complete accurate Minimum Data Set assessments for four of 38 residents reviewed (Residents 8, 18, 25, 80). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides guidance and instructions for the completion of Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October, 2019, indicated that the intent of Section O was to record special treatments and programs that were provided to the resident during the seven-day lookback period. Section O0250C was to be coded with the reason the influenza vaccine was not received. A quarterly MDS assessment for Resident 8, dated	F 0641		

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F 0641 SS=D	Continued from page 8 February 28, 2023, indicated that the resident was usually understood and could usually understand others, required extensive assistance from staff for his daily care tasks, and had a diagnosis that included dysarthria (speech disorder caused by muscle weakness). Section O0250C revealed that the resident was offered but declined the influenza vaccine. An Informed Consent for Influenza Vaccine form for Resident 8, dated December 27, 2022, revealed that the resident gave consent to receive the influenza vaccine. There was no documented evidence that the resident declined or refused the influenza vaccine. The RAI User's Manual, dated October 2019, revealed that Section O0100 was to be completed for the resident's special treatments, procedures, and programs. Section O0100C was to be coded for the use of oxygen. Column (1) was to be checked if oxygen was used while not a resident of the facility within the last 14 days, and column (2)	F 0641		

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F 0641 SS=D	Continued from page 9 was to be checked if oxygen was used while a resident of the facility within the last 14 days. Physician's orders for Resident 18, dated January 6, 2023, included an order for the resident to receive continuous oxygen at 2 liters per minute (flow rate) via nasal cannula (tubes that deliver oxygen into the nostrils) and to titrate (adjust the flow rate) as needed to ensure that the oxygen concentration/pulse oximetry (percentage of oxygen in blood) was equal to or greater than 90 percent every shift. The resident's Medication Administration Records (MAR's) for April and May 2023 indicated that the resident used oxygen daily at 2 liters per minute. However, a quarterly MDS assessment for Resident 18, dated May 4, 2023, revealed that Section O0100C, Column 2 was not checked to indicate that the resident used oxygen during the 14-day assessment period. Interview with the Interim Nursing Home Administrator on May 18, 2023, at 10:05 a.m. confirmed that Section O0100C, Column 2 was not	F 0641		

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F 0641 SS=D	Continued from page 10 coded correctly on Resident 18's MDS assessment of May 4, 2023. The RAI User's Manual, dated October 2019, indicated that the intent of Section N0350A was to record the number of days the resident received insulin during the seven-day look-back period. The intent of Section N0410E was to record the number of days the resident received an anticoagulant (blood thinner) during the seven-day look-back period. The intent of Section N0410G was to record the number of days the resident received a diuretic (increases the amount of urine made by the body) during the seven-day look-back period. Physician's orders for Resident 25, dated November 25, 2022, included an order for the resident to receive 5 milligrams (mg) of Eliquis (an anticoagulant) two times a day. Review of the May 2023 MAR for Resident 25 revealed that the resident was given Eliquis seven days during the look-back period. There was no documented evidence that a diuretic was administered.	F 0641		

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F 0641 SS=D	Continued from page 11 A quarterly MDS for Resident 25, dated May 14, 2023, revealed that the resident was understood and able to understand others, required supervision with daily care needs, and had diagnoses that included Down Syndrome. Section N0410E was coded as (0), indicating the resident did not receive an anticoagulant during the look-back period. Section N0410G was coded as (7), indicating the resident received a diuretic seven days during the look-back period. A quarterly MDS for Resident 80, dated February 22, 2023, revealed that the resident was cognitively intact, required supervision with daily care needs, and had diagnoses that included diabetes. Section N0350A was coded as (7), indicating the resident received insulin seven days during the look-back period. Section N0410G was coded as (7), indicating the resident received a diuretic seven days during the look-back period.	F 0641		

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F 0641 SS=D	Continued from page 12 There was no documented evidence that Resident 80 had a physician's order for insulin or a diuretic, and a review of the MAR for Resident 80 for February 2023 revealed no documentation that the resident received insulin or a diuretic during the seven-day look-back period. An interview with the Nursing Home Administrator on May 18, 2023, at 10:55 a.m. confirmed that the above-mentioned MDS assessments for Residents 8, 25, and 80 were coded incorrectly. 28 Pa. Code 211.5(f) Clinical records.	F 0641		
F 0657 SS=D		F 0657		

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F 0657 SS=D	Continued from page 13 483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 0657	Resident # 25's care plan was reviewed and revised for risk of deep vein thrombosis (aka DVT) and interventions were put into place. Elopement interventions were also reviewed and revised by the RNAC (aka Registered Nurse Assessment Coordinator) and added to the care plan. Resident #35's tube feeding care plan was revised by the RNAC to discontinue the tube feeding. Residents at risk for elopement, DVT, and tube feeding were reviewed to ensure that a resolution was completed on inactive conditions and appropriate interventions are in place and documented by the IDT team. Nursing staff were educated by the Vice President of Clinical Services on updating care plans to ensure active diagnosis and resolving care plans and interventions. Nursing staff were also educated, by the Director of Nursing/designee, on performing interventions that are in the plan of care and documentation	Completion Date: **06/02/2023** Status: **APPROVED** Date: **06/08/2023**

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F 0657 SS=D	Continued from page 14 Based on [illegible]	F 0657	of interventions. As residents needs changes, the care plans will be updated with their new information and reviewed as needed to ensure that resolution, interventions and following interventions with documentation on residents that have an ARD (aka Assessment Review Date) for the week or a change in condition by the IDT (aka Interdisciplinary Team) for 4 weeks then monthly for 2 months. This will be updated in our Policy and Procedure on care planning and will follow our Policy and Procedure.	
F 0684 SS=D		F 0684		

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F 0684 SS=D	Continued from page 15 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	Resident # 25's orders and Medication Administration Records were reviewed and tubigrips were applied as per the physician's order. Resident's #77's physician orders and Medication Administration Record were reviewed, and resident was assessed for any ill effects and the physician was notified of the missing medication on 4/7/23, 4/14/23, and 4/18/23. Audit completed on all residents with tubigrips to ensure that physician's order is in place. Daily medication administration audit (aka baseline audit) of all residents to determine if there are any other missed medications. Licensed nursing staff were educated to ensure that physician's order for tubigrips is in place. All licensed nursing staff re-educated on medication administration and documentation. Audit treatment records to be completed by Director of	Completion Date: **06/02/2023** Status: **APPROVED** Date: **06/08/2023**

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SOMERSET HEALTHCARE & REHABILITATION CENTER STATE LICENSE NUMBER: **970202**	**228 SIEMON DRIVE SOMERSET, PA 15501**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0684 SS=D	Continued from page 16	F 0684	Nursing/designee daily times 2 weeks then weekly times 2 weeks then monthly times 2 months. Daily medication administration audits (aka baseline audit) will continue to be completed on all residents to determine if there are any other missed medications. All of the findings will be reported by the Director of Nursing at the monthly Quality Assurance Performance Improvement meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0684 SS=D	Continued from page 17 Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that physician's orders for medications were followed for two of 38 residents reviewed (Residents 25, 77). Findings include: An Admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 25, dated May 14, 2023, revealed that the resident was understood and able to understand others, required supervision with daily care needs, and had diagnosis that included Down's Syndrome. Physician's orders for Resident 25, dated August 30, 2022, included and order for the resident to wear tubigrip (elastic bandage that provides compression to reduce swelling) to bilateral lower extremities from toe to knee, on every morning and off every evening for edema (swelling).	F 0684		

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F 0684 SS=D	Continued from page 18 Resident 25's potential for impaired skin integrity care plan, dated April 14, 2023, included an intervention to use tubigrip to bilateral lower extremities from toe to knee, on every morning and off every evening for edema. Review of the Medication Administration Records (MAR) for Resident 25 for April and May 2023 revealed no documented evidence that tubigrip was worn on the resident as ordered. Observations on May 16, 2023, at 1:52 p.m. revealed that Resident 25 sitting in his wheelchair in his room wearing socks and sneakers. There were no tubigrip or compression stockings of any kind on his legs. An interview with the Director of Nursing at that time confirmed that the resident was not wearing tubigrip. Interview with the Director of Nursing on May 17, 2023, at 11:18 p.m. confirmed that Resident 25 had a physician's order to wear tubigrip on his bilateral lower legs; however, there was no documented	F 0684		

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F 0684 SS=D	Continued from page 19 evidence in the previous two months that the resident had worn the tubigrip as ordered. A quarterly MDS assessment for Resident 77, dated February 22, 2023, revealed that the resident was sometimes understood, could sometimes understand, and had a diagnosis of hypothyroidism (when the thyroid gland does not make enough thyroid hormones to meet your body's needs). A care plan for the resident, dated February 21, 2023, revealed that the resident had hypothyroidism and staff was to give the resident's thyroid replacement therapy as ordered. Physician's orders for Resident 77, dated April 4, 2023, included an order for the resident to receive one 175 microgram (mcg) tablet of Levothyroxine (a medicine used to treat an underactive thyroid gland (hypothyroidism) every morning. A review of the April 2023 MAR's for Resident 77 revealed that there was no documented evidence that the resident was administered the 175 mcg	F 0684		

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F 0684 SS=D	Continued from page 20 tablet of Levothyroxine on April 7, 14, and 18, 2023. Interview with the Assistant Director of Nursing on May 18, 2023, at 10:45 a.m. confirmed that there was no documented evidence that Resident 77 was administered the 175 mcg tablet of Levothyroxine on April 7, 14, and 18, 2023. 28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0684		
F 0686 SS=D		F 0686		

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F 0686 SS=D	Continued from page 21 483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 0686	Resident #35's wound was assessed by the wound nurse on 5/18/2023. Interventions for residents identified as having the potential to be affected: 1. A skin sweep will be completed on all residents and any areas/blemishes will be recorded. 2. Nurse aides to be educated on shower sheets and marking all areas whether old or new. If areas noted, they must be verbally reported to the nurse including but not limited to bruises. Nurse aides to also be educated on preventable skin interventions. 3. Licensed staff and therapy to be educated on new skin areas including bruises. New skin area of any nature must have a non-fall incident report and investigation completed. 4. Nurse/designee in charge of skin program will see new area and any	Completion Date: **06/09/2023** Status: **APPROVED** Date: **06/08/2023**

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F 0686 SS=D	Continued from page 22	F 0686	admission or readmission within 24 hours -if a weekend, this will be done the following Monday. 5. Wound nurse to see all wounds, weekly, regardless of whom is seen by the facility nurse practitioner or wound clinic. 6. New areas will be discussed with the IDT (Interdisciplinary Team) in the weekly programs meeting. Systematic Change: 1. Nurse/designee in charge of the skin program will see new area and any admission or re-admission within 24 hours-if a weekend, it will occur on Monday. 2. New areas will be discussed with the IDT in weekly programs meeting. 3. Director of Nursing/designee will complete wound rounds weekly and document findings in the notes in the electronic medical record.	

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F 0686 SS=D	Continued from page 23	F 0686	Monitoring of the change to sustain system compliance: 1. Director of Nursing/designee will audit 10 residents weekly to ensure new areas are documented by all clinical disciplines and all wounds will be documented weekly for 4 weeks then every other week for 4 weeks then monthly. 2. Findings will be reported by the Director of Nursing to the Quality Assurance Performance Improvement Meeting for review and recommendations.	

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F 0686 SS=D	Continued from page 24 Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that pressure ulcers were monitored for one of 38 residents reviewed (Resident 35). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 35, dated April 19, 2023, revealed that the resident was cognitively intact, required extensive assistance with daily care needs, and had diagnoses that included diabetes and the presence of open wounds. A care plan for the potential for impaired skin integrity for Resident 35, dated May 10, 2022, indicated that the care and treatment included weekly wound assessments with documentation to include the width, length, depth, type of tissue, exudate, and any other notable changes or observations for each area of skin breakdown.	F 0686		

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F 0686 SS=D	Continued from page 25 A review of Resident 35's clinical record, including nursing notes, physician's notes, and wound clinic consultations, revealed no documented evidence that weekly wound assessments were completed as care planned. A wound clinic consultation for Resident 35 revealed that the resident had a follow up appointment scheduled for May 23, 2023. An interview with the Director of Nursing and Registered Nurse 1 on May 17, 2023, at 3:15 p.m. confirmed that weekly wound assessments were not done in the facility. The resident is followed by an outside wound clinic and they determine the resident's wound treatments. An interview with the Director of Nursing on May 18, 2023, at 2:51 p.m. confirmed that Resident 35's care plan indicated to complete weekly wound assessments, so they should have been completed.	F 0686		

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F 0686 SS=D	Continued from page 26 An interview with the Nursing Home Administrator on May 18, 2023, at 8:45 a.m. confirmed that there was no documentation of weekly wound assessments for Resident 35. 28 Pa. Code 211.12(d)(5) Nursing services.	F 0686		
F 0695 SS=E		F 0695		

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F 0695 SS=E	Continued from page 27 483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 0695	Resident #17's order was entered for tubing change. The tubing was changed and dated right during the survey. Resident #17's order for oxygen was changed and no oximeter was needed. Review of all residents on oxygen was completed by 5/19/2023 to ensure tubing change was ordered and if applicable pulse oximeter order is being monitored by the Director of Nursing. Tubing on all residents using oxygen were checked on 5/19/2023 by nursing staff and dated appropriately. Licensed nursing staff educated by the Director of Nursing on dating oxygen tubing. Pulse oximeter obtained when titrating then documenting tube change and pulse oximeter. Residents with a new order for oxygen or new admit with oxygen will be reviewed at clinical morning meeting to ensure orders are implemented and that documentation is present by the clinical team.	Completion Date: **06/09/2023** Status: **APPROVED** Date: **06/08/2023**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 7/12/2023
FORM APPROVED
2567-L

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395398	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 05/18/2023

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F 0695 SS=E	Continued from page 28 [illegible]	F 0695	Residents requiring pulse oximeter will be placed on the Medication Administration Record (MAR) and the Director of Nursing will monitor for holes in the MAR. Residents that are on continuous oxygen that are stable will be reviewed by the physician as needed. New orders for oxygen will be reviewed weekly for 4 weeks then monthly for 2 months to ensure that the oxygen tubing is changed and documented and that the pulse oximeter is documented when applicable for titration. This will be reviewed at the monthly Quality Assurance and Performance Improvement Meeting.	
F 0711 SS=D		F 0711		

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F 0711 SS=D	Continued from page 29 483.30(b)(1)-(3) Physician Visits - Review Care/Notes/Order §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by:	F 0711	Resident #78's nurse practitioner's notes were received on 5/18/23. Residents were reviewed to ensure all nurse practitioner notes were uploaded in the system for the past six months. The nurse practitioner was educated by the D.O.N. (aka Director of Nursing) on documentation of visits and notes to be provided to the facility. The Medical records Director was also educated by the DON on obtaining notes and uploading nurse practitioner notes into the electronic medical record and to follow up if not receiving notes with the DON. Medical Records Director will also be notified of the nurse practitioner visit and will ensure the notes are received in a timely manner and uploaded into the system. Nurse practitioner visits and notes to be reviewed by the D.O.N. to ensure notes are received and uploaded in a timely manner. The	Completion Date: **06/09/2023** Status: **APPROVED** Date: **06/08/2023**

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F 0711 SS=D	Continued from page 30	F 0711	findings will be reported at the monthly Quality Assurance Performance Improvement meeting.	

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F 0711 SS=D	Continued from page 31 Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that the certified registered nurse practitioner wrote progress notes with each visit for one of 38 residents reviewed (Resident 78). Findings include: A nursing note for Resident 78, dated February 6, 2023, revealed that Certified Registered Nurse Practitioner 4 (CRNP - a registered nurse with advanced training and the authority to write orders for treatment) saw the resident during wound rounds. New orders were received to cleanse the resident's coccyx (also know as the tailbone) with wound cleanser, apply triple antibiotic ointment, cover with border foam, and change the dressing every two days and as needed. However, CRNP 4's progress note for Resident 78, dated February 6, 2023, did not include his assessment of the resident's wound to her coccyx area. A nursing note for Resident 78, dated February 13,	F 0711		

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F 0711 SS=D	Continued from page 32 2023, revealed that CRNP 4 saw the resident during wound rounds. New orders were received to cleanse the resident's right ischium (forms the lower and back part of the hip bone) with normal sterile saline (sterile salt water), apply triple antibiotic ointment, cover with border foam, and change the dressing every two days and as needed. Staff was to discontinue the current treatments to the resident's right lateral malleolus (outside part of the ankle) and to her right buttock. There was no documented evidence that CRNP 4's February 13, 2023, progress note for Resident 78 was part of the clinical record. Interview with Registered Nurse 1 and the Director of Nursing on May 17, 2023, at 1:15 p.m. confirmed that CRNP 4's note for Resident 78 from February 6, 2023, did not include his assessment of the resident's coccyx wound and that there was no documented evidence of his note from February 13, 2023, in the resident's clinical record. Interview with the Director of Nursing on May 18,	F 0711		

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F 0711 SS=D	Continued from page 33 2023, at 2:50 p.m. revealed that he had the physician's office fax over Resident 78's February 13, 2023, note from CRNP 4 today. 28 Pa. Code 211.5(f) Clinical records.	F 0711		
F 0730 SS=D		F 0730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395398	A. BLDG: 00 B. WING:	05/18/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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F 0730 SS=D	Continued from page 34 483.35(d)(7) Nurse Aide Peform Review-12 hr/yr In-Service §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by:	F 0730	Nurse Aide 3 did not have their annual evaluation available. An audit tool using a tickler file system was conducted by the Human Resources Director on 6/5/23 to ensure that all other staff member evaluations were conducted as required and will continue to be completed as required. The Human Resources Director and other Department Managers will be re-educated on ensuring that 100% of evaluations are completed when due. Staff member evaluations due, if any, in the next 30 days will be audited by the Human Resources Director to ensure compliance. Human Resources will then monitor for compliance for all annual evaluations due for the next 2 months. Results will be reported at the monthly Quality Assurance Performance Improvement meeting.	Completion Date: **06/09/2023** Status: **APPROVED** Date: **06/08/2023**

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F 0730 SS=D	Continued from page 35 Based on a list of nurse aides provided by the facility and their personnel files, as well as staff interviews, it was determined that the facility failed to ensure that nurse aide performance evaluations were completed annually based on the hire dates for one of four nurse aides reviewed (Nurse Aide 3). Findings include: A review of the personnel file for Nurse Aide 3 revealed a hire date of January 11, 2007, with performance evaluations completed on January 12, 2023, and January 26, 2023. However, there was no documented evidence that her annual performance evaluation was completed as required in January 2022. Interview with the Director of Human Services on May 17, 2023, at 1:55 p.m. confirmed that there was no documented evidence that Nurse Aide 3 had an annual performance evaluation completed as required in January 2022.	F 0730		

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F 0730 SS=D	Continued from page 36 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management. 28 Pa. Code 201.20(a)(c) Staff development.	F 0730		
F 0755 SS=D		F 0755		

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F 0755 SS=D	Continued from page 37 483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 0755	Residents # 22 and #80 Medication Administration Records were reviewed with the narcotic sheets on 5/19/23. Residents # 22 and #80 orders were changed to include signatures as per policy. Resident # 22 and #80's MAR and narcotic sheets were reviewed by the IDT (aka Interdisciplinary Team). Licensed nursing staff were educated on documentation of as needed medication on the Medication Administration Record (MAR) and narcotic sheet. Licensed nursing staff were also educated to immediately report any problem with the narcotics sheet/medication administration record to the Director of Nursing or Executive Director. Nurse managers will review narcotic sheets 3 times a week for 4 weeks to ensure that medications are also being documented on the MAR by the Director of Nursing and then monthly for 2 months. This will be reported by the Director of Nursing	Completion Date: **06/09/2023** Status: **APPROVED** Date: **06/08/2023**

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F 0755 SS=D	Continued from page 38 This REQUIREMENT is not met as evidenced by:	F 0755	at the monthly Quality Assurance Performance Improvement Meeting.	

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F 0755 SS=D	Continued from page 39 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to maintain accountability for controlled medications (drugs with the potential to be abused) for two of 38 residents reviewed (Residents 22, 80). Findings include: A facility policy for medication dispensing, dated January 13, 2023, indicated that controlled drugs are documented as given at the time of administration as specified by federal and state regulations. A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 22, dated May 2, 2023, revealed that the resident was cognitively intact, required extensive assistance with daily care needs, and had diagnosis of pain. Physician's orders for Resident 22, dated February	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0755 SS=D	Continued from page 40 13, 2023, included orders for the resident to receive one 5-325 milligrams (mg) tablet of Hydrocodone-Acetaminophen (a controlled narcotic pain medication) every six hours as needed for severe pain. Review of Resident 22's controlled drug record (a form used to account for each dose of a controlled medication) for April 2023 revealed that one 5-325 mg tablet of Hydrocodone-Acetaminophen was signed-out by staff for administration to the resident on April 3, 7, 13, 14, 26, and 30, 2023. However, there was no documented evidence in the resident's clinical record, including on the Medication Administration Record (MAR), to indicate that staff actually administered the medication or that the medication was destroyed for any reason. Physician's orders for Resident 22, dated January 31, 2023, included orders for the resident to receive a 12 microgram (mcg) per hour Fentanyl patch (a controlled narcotic pain medication) transdermally every three days for chronic pain, and an order to	F 0755		

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F 0755 SS=D	Continued from page 41 have a witness signature the disposal of the Fentanyl patch every three days. Review of the controlled drug record for Resident 22 for April 2023 revealed that one 12 mcg per hour Fentanyl patch was signed out by staff for administration to the resident on April 1, 7, 10, and 13, 2023. However, there was no documented evidence in the resident's clinical record, including on the MAR, that there was a witness signature when the Fentanyl patch was disposed of. Interview with the Nursing Home Administrator on May 17, 2023, at 2:44 p.m. confirmed that there was no documented evidence that doses of Hydrocodone-Acetaminophen were actually administered to Resident 22 and no documented evidence of a witness signature when the Fentanyl patch was disposed of. A quarterly MDS for Resident 80, dated February 22, 2023, revealed that the resident was cognitively intact, required supervision with daily care needs,	F 0755		

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F 0755 SS=D	Continued from page 42 and had diagnoses that included diabetes. Physician's orders for Resident 80, dated April 12, 2023, included an order for the resident to receive 0.5 milligrams (mg) of Clonazepam (a controlled drug) every six hours as needed for anxiety. Review of the controlled drug record for Resident 80 for April 2023 indicated that a Clonazepam dose was signed out by staff on April 14, 2023, at 8:10 a.m.; April 18, 2023, at 8:00 a.m.; April 24, 2023, at 8:08 a.m.; and April 30, 2023, at 7:55 p.m. However, the resident's clinical record, including the MAR and nursing notes, contained no documented evidence that the signed-out doses of Clonazepam were administered to the resident on these dates and times. Interview with the Nursing Home Administrator on May 18, 2023, at 11:00 a.m. confirmed that there was no documented evidence in Resident 80's clinical records to indicate that the signed-out doses of Clonazepam mentioned above were administered	F 0755		

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F 0755 SS=D	Continued from page 43 to the resident. 28 Pa. Code 211.9(h) Pharmacy services. 28 Pa. Code 211.12(d)(1) Nursing services. 28 Pa. Code 211.12(d)(5) Nursing services.	F 0755		
F 0758 SS=D		F 0758		

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F 0758 SS=D	Continued from page 44 483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 0758	Resident #80's Clonazepam (an anxiolytic) was discontinued on 6/8 after a discussion with the primary care physician. All residents will be reviewed by the attending physician that have had a new order for psychoactive medication in the last week to ensure initial order was for 14 days and reviewed for continuation and rationale as per our facility policy and procedure. Licensed nursing staff to be educated on any new psychoactive medication must only be ordered for 14 days and review rationale to continue usage by the Director of Nursing. New psychoactive medication will be reviewed in the morning clinical meeting to ensure a 14-day order was obtained. New psychoactive medications will be reviewed weekly by the Director of Nursing to ensure a 14-day order was obtained and that the rationale to continue was obtained if	Completion Date: **06/09/2023** Status: **APPROVED** Date: **06/09/2023**

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F 0758 SS=D	Continued from page 45 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:	F 0758	applicable for 4 weeks, then monthly for 2 months.	

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F 0758 SS=D	Continued from page 46 Based on facility policy and CMS (Centers for Medicare & Medicaid Services) guidelines, as well as clinical record reviews and staff interviews, it was determined that the facility failed to ensure that residents were free from unnecessary medications for one of 38 residents reviewed (Resident 80). Findings include: A facility policy for Psychotropic Drug Use, dated January 3, 2023, included that dosage reductions of anxiolytics (used to reduce anxiety) are attempted per CMS guidelines unless clinically contraindicated. CMS guidelines include the Code for Federal Regulations (CFR) 483.45(e)(4) that as-needed orders for psychotropic (cause changes in mood and behavior; includes anxiolytics) drugs are limited to 14 days. Except as provided in CFR 483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the as-needed order to be extended beyond 14 days,	F 0758		

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F 0758 SS=D	Continued from page 47 he or she should document their rationale in the resident's medical record and indicate the duration for the as-needed order. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 80, dated February 22, 2023, revealed that the resident was cognitively intact, required supervision with daily care needs, and had diagnosis that included diabetes and anxiety. Physician's orders for Resident 80, dated April 12, 2023, included that the resident receive 0.5 milligrams (mg) of Clonazepam (an anxiolytic) every six hours as needed for anxiety until end of life. A review of clinical records, including physician progress notes for Resident 80, revealed no documented rationale for the long-term use of Clonazepam as needed, as required by federal law. An interview with the Director of Nursing on May	F 0758		

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F 0758 SS=D	Continued from page 48 17, 2023, at 11:18 a.m. confirmed that there was no documented rationale for the long-term use of as-needed clonazepam by the attending physician or by a psychiatric consultant. 28 Pa. Code 211.12(d)(5) Nursing services.	F 0758		
F 0760 SS=E		F 0760		

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F 0760 SS=E	Continued from page 49 483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by:	F 0760	Residents # 17 and #77 had the following interventions completed: a. Med error corrected. b. Doctor notification. c. Family notification. d. Resident assessed for negative outcomes. e. Medication errors were completed for resident with insulin not administered. f. Medication error completed for Synthroid duplicate order. Interventions for residents identified as having the potential to be affected: 1. All medications reviewed for admin on 5/3/23 2. Medication errors completed 3. Doctor notification 4. Family notification 5. All residents that receive sliding scale insulin were reviewed to ensure they are receiving appropriate coverage. Licensed staff educated on documenting sliding scale insulin and coverage.	Completion Date: **06/09/2023** Status: **APPROVED** Date: **06/12/2023**

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F 0760 SS=E	Continued from page 50	F 0760	6. All residents were reviewed to ensure that they did not have duplicate orders for Synthroid. Licensed staff educated on documenting throxine. Systematic Change: 1. Nurse involved educated on 6 rights to include process for if medications are going to be late 2. All nurses educated on 6 rights to include timely administration, process for if medication is going to be late by DON 3. Ad hoc Quality Assurance Performance Improvement meeting occurred on Monday (5/8) to review findings. 4. Pharmacist reviewed medications to see medication load at med times. 5. Nurse involved not to assume a medcart. 6. Licensed staff were educated on sliding scale insulin and coverage and also documenting sliding scale insulin and coverage and thyroxine. 7. Licensed staff were educated on	

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F 0760 SS=E	Continued from page 51	F 0760	duplicate medications and discontinuing orders with start of new orders. Monitoring of the change to sustain system compliance ongoing: 1. Monitor resident #17 and # 77 medications 5 times a week to ensure medications are timely for 4 weeks. 2. Nurse manager to perform med pass observation randomly on nurses on variable shifts 2 times a week for 4 weeks. 3. Nurse manager to monitor sliding scale insulin and blood sugars and Synthroid for duplicate orders five times a week for 4 weeks. 4. Findings to be reviewed with Quality Assurance Performance Improvement for review and recommendations by the Director of Nursing.	

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F 0760 SS=E	Continued from page 52 Based on review of clinical records and staff interviews, it was determined that the facility failed to ensure that it was free from significant medication errors for two of 38 residents reviewed (Residents 17, 77). Findings include: An Annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 17, dated April 6, 2023, revealed that the resident was understood and able to understand others, required extensive assist with daily care needs, had diagnoses that included diabetes (a disease that interferes with blood sugar control), and received insulin. Physician's orders for Resident 17, dated May 4, 2021, included an order to check the resident's blood sugar before meals and at bedtime. Physician's orders, dated May 9, 2022, included an order for the resident to receive 3 units of Humalog	F 0760		

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F 0760 SS=E	Continued from page 53 (fast acting) insulin if her blood sugar is between 201 milligrams per deciliter (mg/dl) and 250 mg/dl, 6 units of Humalog insulin if her blood sugar is between 251 mg/dl and 300 mg/dl, 9 units of Humalog insulin if her blood sugar is between 301 mg/dl and 350 mg/dl, 12 units of Humalog insulin if her blood sugar is between 351 mg/dl and 400 mg/dl, and 16 units of Humalog insulin if her blood sugar is between 401 mg/dl and 450 mg/dl. A review of the Medication Administration Records (MAR's) for Resident 17 for April and May 2023 revealed that the resident's blood sugar on April 5, 2023, at 4:30 p.m. was 211 mg/dl; on April 6, 2023, at 4:30 p.m. was 233 mg/dl; on April 8, 2023, at 4:30 p.m. was 227 mg/dl; on April 9, 2023, at 4:30 p.m. was 211 mg/dl; on April 14, 2023, at 11:30 a.m. was 300 mg/dl; on April 18, 2023, at 11:30 a.m. was 205 mg/dl; on April 23, 2023, at 4:30 p.m. was 234 mg/dl; on April 24, 2023, at 4:30 p.m. was 212 mg/dl; on April 26, 2023, at 11:30 a.m. was 313 mg/dl; on May 6, 2023, at 4:30 p.m. was 207 mg/dl; and on May 10,	F 0760		

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F 0760 SS=E	Continued from page 54 2023, at 11:30 p.m. was 204 mg/dl. There was no documented evidence that the Humalog insulin was given for blood sugars greater than 200 mg/dl on these dates and times as ordered by the physician. Interview with the Nursing Home Administer on May 18, 2023, at 12:11 p.m. confirmed that sliding scale Humalog insulin was not administered on the above-mentioned dates and time but should have been. A quarterly MDS assessment for Resident 77, dated February 22, 2023, revealed that the resident was sometimes understood, could sometimes understand, and had diagnoses that included hypothyroidism (when the thyroid gland does not make enough thyroid hormones to meet your body's needs). A care plan for the resident, dated March 21, 2023, revealed that the resident had hypothyroidism and staff was not to change the resident's thyroid medications without consulting the endocrinologist (a doctor that treats diseases related to problems with hormones).	F 0760		

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F 0760 SS=E	Continued from page 55 A nursing note for Resident 77, dated April 4, 2023, at 6:53 a.m. revealed that Certified Registered Nurse Practitioner 5 (CRNP - a registered nurse with advanced training and the authority to write orders for treatment) was in the facility and made aware of the resident's thyroid stimulating hormone (TSH - a blood test that measures this hormone) laboratory results. A new order was received to administer one 150 microgram (mcg) tablet of Levothyroxine (a medicine used to treat an underactive thyroid gland (hypothyroidism)) every morning and staff was to discontinue the administration of the 125 mcg tablet of Levothyroxine every morning. A nursing note for Resident 77, dated April 4, 2023, at 10:43 a.m. revealed that per the endocrinologist the resident was to be administered one 175 mcg tablet of Levothyroxine every morning and staff was to discontinue the administration of the 150 mcg tablet of Levothyroxine every morning.	F 0760		

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F 0760 SS=E	Continued from page 56 There was no documented evidence in Resident 77's clinical record that the 150 mcg dose of Levothyroxine was discontinued until April 16, 2023. The medication administration records for Resident 77 for April 2023 revealed that staff administered the 150 mcg and the 175 mcg doses of Levothyroxine together on April 5, 6, 8, 11, 12, 13, and 15, 2023. Interview with the Assistant Director of Nursing on May 18, 2023, at 10:45 a.m. confirmed that staff administered both the 150 mcg and the 175 mcg doses of Levothyroxine to Resident 77 on the above dates. 28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0760		
F 0867 SS=D		F 0867		

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F 0867 SS=D	Continued from page 57 483.75(c)(d)(e)(g)(2)(i)(ii) QAPI/QAA Improvement Activities §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including	F 0867	A subcommittee of the Quality Assurance Performance Improvement Committee will be developed to review the following F tags (F 689, F 730, F 760, F 880, and F 883) Each F tag mentioned will be audited to determine if there is improvement. If improvement is not noted, then the subcommittee will utilize a root cause analysis to determine what could be changed to prevent these recurring deficiencies. Performance Improvement Plans (PIPs) will be developed for each F tag mentioned before to directly monitor each F tag's improvement. The findings will be present, by the head of the subcommittee (the Administrator/designee), monthly, to the Quality Assurance Performance Improvement for review and recommendations.	Completion Date: **06/09/2023** Status: **APPROVED** Date: **06/12/2023**

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F 0867 SS=D	Continued from page 58 the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the	F 0867		

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F 0867 SS=D	Continued from page 59 incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:	F 0867		

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F 0867 SS=D	Continued from page 60 (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by:	F 0867		

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F 0867 SS=D	Continued from page 61 Based on review of the facility's plans of correction and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies. Findings include: The facility's deficiencies and plans of correction for a State Survey and Certification (Department of Health) survey ending May 25, 2022, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility-maintained compliance with cited nursing home regulations. The results of the current survey ending May 18, 2023, identified repeated deficiencies regarding accident hazards, nurse aide performance reviews, significant medication errors, infection control, and influenza and pneumococcal vaccines.	F 0867		

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F 0867 SS=D	Continued from page 62 The facility's plan of correction for a deficiency regarding a failure to ensure that the resident environment remained free from accident hazards, cited during the survey ending May 25, 2022, revealed that the facility developed a plan that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F689, revealed that the QAPI committee failed to successfully implement their plan to ensure ongoing compliance with the regulations regarding accident hazards. The facility's plan of correction for a deficiency regarding a failure to ensure ongoing compliance with the regulations regarding nurse aide performance reviews, cited during the survey ending May 25, 2022, revealed that the facility developed a plan that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F730, revealed that the QAPI committee	F 0867		

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F 0867 SS=D	Continued from page 63 failed to successfully implement their plan to ensure ongoing compliance with the regulations regarding nurse aide performance reviews. The facility's plan of correction for a deficiency regarding a failure to ensure ongoing compliance with the regulations regarding significant medication errors, cited during the survey ending May 25, 2022, revealed that the facility developed a plan that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F760 revealed that the QAPI committee failed to successfully implement their plan to ensure ongoing compliance with the regulations regarding significant medication errors. The facility's plan of correction for a deficiency regarding a failure to maintain an effective infection control program, cited during the survey ending May 25, 2022, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI	F 0867		

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F 0867 SS=D	Continued from page 64 committee for review. The results of the current survey, cited under F880, revealed that the facility's QAPI committee failed to successfully implement their plans to ensure ongoing compliance with regulations regarding infection control. The facility's plan of correction for a deficiency regarding a failure to ensure ongoing compliance with the regulations regarding influenza and pneumococcal vaccines, cited during the survey ending May 25, 2022, revealed that the facility developed a plan that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F883, revealed that the QAPI committee failed to successfully implement their plan to ensure ongoing compliance with the regulations regarding influenza and pneumococcal vaccines. Refer to F689, F730, F760, F880, F883. 28 Pa. Code 201.14(a) Responsibility of licensee.	F 0867		

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F 0880 SS=D		F 0880		

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F 0880 SS=D	Continued from page 66 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	Interventions for affected resident: Resident #81's door immediately had a sign added advising staff to be aware of Methicillin Resistant Staphylococcus Aureus (MRSA) precautions. In addition, the resident's catheter bag was removed from the floor and replaced. Interventions for residents identified as having the potential to be affected: Residents with a Foley catheter were reviewed with the nurses' aides or nurses to ensure they are never on the floor and always placed appropriately-that being above the floor and below the bladder. Infections reviewed for appropriate isolation precautions by the Interdisciplinary care plan team. Nursing staff to be educated on MRSA and the appropriate isolations precautions to be taken as per CDC guidance.	Completion Date: **06/09/2023** Status: **APPROVED** Date: **06/12/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0880 SS=D	Continued from page 67 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880	Systematic Change: Residents with foleys bags will be reviewed to ensure bag is placed appropriately. Infections will be reviewed by the interdisciplinary care plan team to ensure appropriate Isolation precautions are implemented based on Centers for Disease Control (C.D.C.) guidance. Monitoring of the change to sustain system compliance ongoing: Foley bags will be checked by the Director of Nursing (D.O.N.) or designee to ensure they are not on the floor 5 times a week for 4 weeks then randomly for 2 months. Infections will be reviewed, by the D.O.N. or designee, 5 times a week to ensure appropriate isolation precautions are implemented for 4 weeks then monthly for 2 months.	

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F 0880 SS=D	Continued from page 68	F 0880		

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F 0880 SS=D	Continued from page 69 Based on review of guidance from the Centers for Disease Control (CDC-the national health protection agency) and clinical record review, as well as observations and staff interviews, it was determined that the facility failed to follow proper infection control policies related to urinary catheter care and failed to follow CDC guidelines to reduce the spread of infections and prevent cross-contamination related to Methicillin Resistant Staphylococcus Aureus (MRSA - a type of multidrug-resistant organism) infection for one of 38 residents reviewed (Resident 81). Findings include: CDC guidance on isolation precautions for MRSA residents contained in Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated July 12, 2022, indicates that multidrug-resistant organism (MDRO) transmission is common in skilled nursing facilities, contributing to	F 0880		

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F 0880 SS=D	Continued from page 70 substantial resident morbidity and mortality and increased healthcare costs. Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization status and/or infection or colonization with an MDRO. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 81, dated April 12, 2023, revealed that the resident was sometimes understood and could sometimes understand others, required extensive assist for daily care needs, had an indwelling urinary catheter (a flexible tube that is inserted into the bladder to drain urine), and had diagnoses that included neurogenic bladder (lack of bladder control)	F 0880		

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F 0880 SS=D	Continued from page 71 Physician's orders for Resident 81, dated May 12, 2023, included an order for the resident to receive 100 milligrams (mg) of Minocycline (an antibiotic) two times a day for ten days for MRSA in the left hip wound. Observations on May 15, 2023, at 11:30 a.m. of Resident 81's room revealed a plastic cart containing personal protective equipment (PPE) beside the room entrance. An interview with Licensed Practical Nurse 7 at that time identified Resident 81 as having MRSA in a wound and confirmed that there was no sign on the resident's door advising staff and visitors of the need for precaution. An interview with the Director of Nursing at this time confirmed that the resident was in isolation for MRSA, and there should be a sign on the door advising precautions Observations of Resident 81 on May 18, 2023, at 10:29 a.m. revealed that the resident was lying in bed with his urinary catheter bag lying on the floor. An interview with Registered Nurse 7 at that time	F 0880		

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F 0880 SS=D	Continued from page 72 confirmed that the resident's catheter bag was lying on the floor and should not have been. Interview with the Infection Control Nurse on May 18, 2023, at 10:48 p.m. revealed that Resident 81 was being treated for a MRSA infection in his left hip wound, and that only standard precautions were required because his wound was contained in a clean dressing. She further revealed that the facility's policy is to use standard precautions for the care and treatment of an active MRSA infection and that contact precautions (including the use of gloves and gowns) were not required for any care, including care of a MRSA infected wound. An interview with the Director of Nursing on May 18, 2023, at 2:52 p.m. revealed that his understanding of CDC recommendations is that contact isolation is not required for MRSA positive wounds if the wound is contained; therefore, contact isolation was not used. 28 Pa. Code 201.14(a) Responsibility of licensee.	F 0880		

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F 0880 SS=D	Continued from page 73 28 Pa. Code 201.18(b)(1)(3)(d)(e)(1) Management. 28 Pa. Code 211.10(d) Resident care policies.	F 0880		
F 0883 SS=D		F 0883		

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F 0883 SS=D	Continued from page 74 483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;	F 0883	Resident #8 will be offered influenza vaccine next season. Family and physician notified of omitted vaccine. Residents were reviewed to ensure that they had received the influenza vaccine if consented. Infection preventionist was educated on administering influenza vaccine when resident is admitted in influenza season by the Vice President of Clinical Services. Infection preventionist was educated on administering influenza vaccine when resident is admitted in influenza season by the Vice President of Clinical Services. The infection preventionist was also educated on keeping a roster of active residents with consents for the vaccine and vaccine administration. Residents will be reviewed on admission and annually to ensure	Completion Date: **06/09/2023** Status: **APPROVED** Date: **06/12/2023**

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F 0883 SS=D	Continued from page 75 (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on review of facility policies and clinical [illegible] each [illegible] 28 Pa. Code 211.12(d)(1)(3) Nursing services.	F 0883	appropriate consent is obtained and vaccine is administered by the infection preventionist. Infection Preventionist will monitor new admissions to ensure influenza consents are signed and resident placed on list for next influenza season weekly for 4 weeks then monthly for 2 months.	

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P 0555		P 0555		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

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P 0555	Continued from page 1 § 201.20(c) Staff development. (c) There shall be at least annual inservice training which includes at least infection prevention and control, fire prevention and safety, accident prevention, disaster preparedness, resident confidential information, resident psychosocial needs, restorative nursing techniques and resident rights, including personal property rights, privacy, preservation of dignity and the prevention and reporting of resident abuse. This REGULATION is not met as evidenced by:	P 0555	Licensed Practical Nurse #8 received their annual training for fire prevention and safety, disaster preparedness, and restorative nursing techniques on 6/8/23 by the Director of Nursing (D.O.N.) and the Maintenance Director. All employees were reviewed by the Human Resources Director on 6/8/23 to ensure that appropriate training was obtained for License Practical Nurse #8 as well as other staff. All employees were trained by the D.O.N. and Maintenance Director on 6/8/23 for restorative nursing techniques, disaster preparedness, and fire prevention and safety. The Human Resources Director will keep a roster of all employees with audits of each employee's files to ensure staff receive appropriate in-servicing. This will be completed by the Human Resources Director for 2 months. Findings will be reported by the	Completion Date: **06/09/2023** Status: **APPROVED** Date: **06/12/2023**

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P 0555	Continued from page 2	P 0555	Human Resources Director to the Quality Assurance Performance Improvement committee for review and recommendations.	

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P 0555	Continued from page 3 Based on a review of employee education records, as well as staff interviews, it was determined that the facility failed to ensure that employees completed the required education for one of eight employee files reviewed (Licensed Practical Nurse 8). Findings include: Review of the education record for Licensed Practical Nurse 8 revealed that she was hired by the facility on April 30, 2015. However, there was no documented evidence of annual training for fire prevention and safety, disaster preparedness, and restorative nursing techniques. Interview with the Director of Human Services on May 18, 2023, at 12:22 p.m. confirmed that there was no documented evidence that the above education was completed annually by Licensed Practical Nurse 8.	P 0555		

Certified End Page

SOMERSET HEALTHCARE & REHABILITATION CENTER

STATE LICENSE NUMBER: 970202

SURVEY EXIT DATE: 05/18/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Acting Secretary of Health

pennsylvania
DEPARTMENT OF HEALTH

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

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